

True Decisions Inc.

An Independent Review Organization

Phone Number:
(512) 298-4786

**2771 E Broad St. Suite 217 #121
Mansfield, TX 76063**

Email: truedecisions@irosolutions.com

Fax Number:
(512) 872-5099

Notice of Independent Review Decision

Case Number:

Date of Notice: 12/12/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Surgery

Description of the service or services in dispute:

Left arthroscopic rotator cuff repair, superior capsular reconstruction, lysis adhesions, extensive debridement, allograft reinforced repair

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

Patient is a male. On 11/01/13, the patient was taken to surgery for a preoperative diagnosis of rotator cuff tear at the left shoulder with impingement, and procedure performed was a left shoulder subacromial decompression with rotator cuff repair. On an unstated date, the patient was taken back to surgery for a left shoulder block and general anesthesia for left shoulder acromioplasty. On 09/11/15, an MRI of the left shoulder revealed a complete chronic rotator cuff tear with secondary upward migration of the humeral head, bursitis and fatty atrophy with marked AC joint arthropathy. On 11/19/15, the patient was seen in clinic. He continued to complain of left shoulder pain. He reported loss of motion and could not raise his arm over his head. On physical examination, he had 3+/5 strength in grip strength, and there was peripheral edema of the left hand and forearm. He had poor range of motion and acute pain with passive range of motion. It was noted he had a complete rotator cuff tear with poor functionality and there was atrophy of the shoulder with anatomic changes palpated at the humerus. He was given a Corticosteroid injection at that time.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 10/05/15, a notice of adverse determination was submitted for the requested left shoulder partial rotator cuff repair and superior capsular reconstruction with human allograft, noting guidelines specifically do not recommend superior capsular reconstruction to augment the repair of a massive rotator cuff tear. It was noted this individual had undergone a single prior rotator cuff repair for the massive cuff tear as well as 2 acromioplasty procedures, and x-rays show evidence of osteoarthritis and there is no report by an independent orthopedic surgeon supporting the requested partial repair and augmentation, with capsular reconstruction with allograft, so the medical necessity of a repeat rotator cuff repair including partial and augmentation of the wrist with allograft reconstruction of the superior capsule was not clearly established. Guidelines utilized were the Official Disability Guidelines shoulder chapter. On 10/07/15, a peer review report

noted the requested left shoulder arthroscopic rotator cuff repair, superior capsular reconstruction, lysis of adhesions, extensive debridement and allograft reinforced repair was non-certified, and utilized the Official Disability Guidelines shoulder chapter. It was noted the submitted documentation did not support that the patient met criteria for surgery as it was noted that during the revision surgery on 08/06/14, the rotator cuff repair was not performed due to the poor quality of the tendon tissue. It was also noted that use of allograft was not recommended as it was considered investigational. Therefore the requested procedure is not considered medically necessary.

The official disability guidelines state a superior capsular reconstruction is not recommended until there are quality studies, and the procedure is investigational. The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. Surgery for adhesive capsulitis, lysis of adhesions, is under study.

It is the opinion of this reviewer that the request for a left arthroscopic rotator cuff repair, superior capsular reconstruction, lysis of adhesions, extensive debridement and allograft reinforced repair is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☒ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☒ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)